FOR OFFICE USE ONLY

Card ☐

Entered ☐

Town of West Hartford Dial-A-Ride
MEMBERSHIP APPLICATION

FOR OFFICE USE ONLY

Date _____

Check # _____

Amount _____

Initials _____

July 1, 2015 – June 30, 2016

Annual Fee: $50.00

Payment must accompany application form.
A separate membership application form and annual fee is required for each household member.

Eligibility:
WH Residents age 65 yrs. or older
WH Residents with Qualified Disability*
*Request separate additional application

Renewal _____ **New** _____

Last Name: _____ First Name: _____

Address: _____ Apt. #_____ West Hartford, CT 061 ____ ____ (Zip Code)

Phone: (860) ____ ____ ____ - ____ ____ ____ ____ Date of Birth: ____ ____ / ____ ____ / ____ ____

Wheelchair Used? Yes _____ No _____ Hearing Impaired? Yes _____ No _____

Wheelchair Type: Electric _____ Manual _____ Visually Impaired? Yes _____ No _____

Special Assistance Required? Yes _____ No _____ Assisted by: Cane _____ Walker _____

Additional Notes: _____

EMERGENCY CONTACT: **Name**: _____

Relationship: _____ **Phone**: _____

_____ _____

Applicant Signature (or Power of Attorney) **Date**

Please make your check payable to **WH Dial-A-Ride** and return completed form with payment to:
West Hartford Dial-A-Ride, 50 South Main Street, Rm. 306, West Hartford, CT 06107.

Please also consider helping the Town sustain the Dial-A-Ride program by making a tax deductible donation.
Thank you for your consideration and generosity!

$50.00 Membership Fee

_____ Additional Donation (tax deductible)

_____ Total Amount Enclosed

Please feel free to contact the office with any questions ~ (860) 561-7561

Town of West Hartford Dial-A-Ride
50 South Main Street, Rm. 306
West Hartford, CT 06107
(860) 561-7561

ADA QUALIFIED DISABILITY QUESTIONNAIRE

_____ _____, West Hartford, CT 061 __ __
(Applicant Name) (Applicant Address)

Information About Your Functional Ability:

For each statement, circle one answer

1. I can cross the street if there are curb cuts.
   Always **Sometimes** **Never**

2. I can travel up/down a gradual hill.
   Always **Sometimes** **Never**

3. I can find my way to the public city bus stop with training.
   Always **Sometimes** **Never**

4. I am able to wait for 10 minutes for a public city bus.
   Always **Sometimes** **Never**

5. I am able to ask for, understand, and follow directions.
   Always **Sometimes** **Never**

6. I am able to detect curbs, ramps, and other drop off areas.
   Always **Sometimes** **Never**

7. I am able to get on and off a public city bus (using stairs_____ or lift_____).
   Always **Sometimes** **Never**

Please Continue On The Opposite Side

Information About Your Disability:

1. What type of disability prevents you from using the public city bus system? (Check all that apply)

   Physical _____ **Visual** _____ **Cognitive** _____ **Mental Health** _____ **Hearing** _____

   Please describe your disability: _____

   _____

2. Do you require the assistance of a personal care attendant?

   Yes _____ **No** _____ **Sometimes** _____

3. Do you use any of the following devices? (Check all that apply):

   _____ **Manual Wheelchair**
   _____ **Electric Wheelchair**
   _____ **Walker**
   _____ **Braces**
   _____ **Crutches**
   _____ **Service Animal**
   _____ **Cart**
   _____ **Power Scooter**
   _____ **Cane**
   _____ **White Cane**
   _____ **Oxygen Tank**
   _____ **Communication Board**
   _____ **None**
   _____ **Other** _____

Certification:

I, _____, hereby certify that the above information is true and correct.
(Applicant Name – Please Print)

_____ _____
Applicant Signature (or Power of Attorney) Date

Town of West Hartford Dial-A-Ride
50 South Main Street, Rm. 306
West Hartford, CT 06107
(860) 561-7561 – Evelyn Lopez
(860) 561-7565 – Ed Sanady

PHYSICIAN CERTIFICATION

I, Dr. _____, hereby certify that the Dial-A-Ride
(Physician's Name – Please Print)

applicant _____, has a disability which prevents them
(Applicant's Name – Please Print)

from being able to access traditional public transportation vehicles (city busses) and is in need of transportation services through the West Hartford Dial-A-Ride Program.

_____ _____
Physician's Signature Date